

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10135  
Reg. Dist. No. 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County KentCity or town Betterton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years.

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Emma C Beauchamp

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female W Widowed.6.(b) Name of husband or wife... James Wesley Beauchamp

7. Birth date of deceased (mo., day, yr.)

Sept - 26 1855

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

92 7 1 hrs. min.

9. Birthplace

Caroline Co Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Home

MOTHER

FATHER

12. Name Alexander Smith13. Birthplace Maryland14. Maiden name Elizabeth Corkran15. Birthplace Maryland16. Informant Mrs Edward DennisAddress Betterton Md17. Burial Date thereof Nov 29 1947  
(Burial, cremation, or removal. Which?)Cemetery or crematory HillsboroLocation Hillsboro Maryland18. Funeral director J. B. HollingsAddress Still Pond Md19. Mourn't 29 1947 J. Hollings  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Betterton Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war. \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947 at 2 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 20 1947 to Nov 26 1947 and that I last saw her alive on Nov 26 1947Immediate cause of death Coronary thrombosisDue to Advanced arteriosclerosis DURATIONDue to Dementia

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

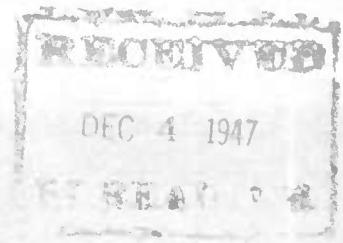
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of \_\_\_\_\_Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James Edwin Dedman M.D. M. D. or otherAddress Betterton, Md. Date signed Nov 28 1947



RECEIVED

DEC 4 1947

R.M.A. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10136  
92d

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

## 1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

life

Hospital, Institution, or street address where death occurred:

Pinney Neck

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charles Wesley Crouch

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

h.

married

6. (b) Name of husband or wife.....

Margaret G. Crouch

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Oct 24 1864

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation.....

Merchant

11. Industry or business.....

General store

MOTHER FATHER

Name.....

Thomasas Crouch

13. Birthplace.....

Rock Hall, Md.

14. Maiden name.....

Jane Colemane

15. Birthplace.....

Rock Hall, Md.

16. Informant.....

Charles Crouch Jr.

Address

Rock Hall, Md.

17. Burial

Date thereof..... Nov 9, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Centreville

Location.....

Centreville Md

18. Funeral director.....

Elvase L. Lane

Address

Church Hill Md

19. Date rec'd by registrar.....

Nov 7, 1947

S. Elvase Lane

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Pinney Neck

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Nov 5 1947

at 10<sup>00</sup>P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1947 to Nov 5 1947

and that I last saw him alive on 11-5 1947

Immediate cause of death.....

Chronic Bronchitis  
Second pneumonia

DURATION

Due to.....

Chronic Bronchitis

Due to.....

Arthritis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

Albert A. Burgard

M. D. or other

Address.....

Rock Hall, Md. Date signed 11/5/47

RECEIVED

NOV 13 1947

6747A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a  
10137

## CERTIFICATE OF DEATH

Reg. Distr. No. 201

## 1. PLACE OF DEATH:

County..... *Hurst*City or town..... *Kennedyville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *all day*

Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Clara Belle Ross Glenn*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Female White Widowed*6.(b) Name of husband or wife..... *(late) George M. Glenn*

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

*January 4 1873*

8. AGE:

Years

Months

Days

If less than one day

*74 10 15*

hrs.

min.

9. Birthplace.....

*Hurst Co. Maryland*

(Town, county, and state)

10. Usual occupation

*housewife*

11. Industry or business

*home*

MOTHER

FATHER

12. Name..... *John Price Van Slyde*13. Birthplace..... *Cecil Co. Maryland*14. Maiden name..... *Achsa Anna Hayes*15. Birthplace..... *Cecil Co. Maryland*16. Informant..... *Mrs. Achsa V. Cross*

Address

*Kennedyville, Maryland*

17. Burial

Date thereof..... *Nov. 22, 1947*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

*Chesapeake*

Location.....

*Chesapeake, Maryland*18. Funeral director..... *Wm. V. Williamson*

Address

*Chesapeake, Maryland*

19. 11-22

1947

*J. Melark?*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Hurst*City or town..... *Kennedyville* (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *November 19 1947* at *12:15 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov. 4 1947* to *Nov. 19 1947* and that I last saw her alive on *Nov. 19 1947*.Immediate cause of death..... *Cerebral thrombosis and hemorrhage* DURATION *5 weeks*

Due to.....

Due to.....

Other conditions..... *Bronchopneumonia 4 days*  
*Gen. arterio sclerosis years* (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Frederick & Papachristi M.D.*

M. D. or other

Address..... *Glenview Md* Date signed *11-20-47*

RECEIVED

DEC 4 1947

AFAC

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

## CERTIFICATE OF DEATH

10138203  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

days

Hospital, Institution, or street address where death occurred:

Days Inn

How long in hospital or institution?.....

## 3. (a) FULL NAME

William Willow Goodman

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m.

f<sub>l</sub>.<sub>h</sub>.

married

6.(b) Name of husband or wife.....

Mary Goodman

7. Birth date of deceased (mo., day, yr.)

Oct 28 1868

8. (c) If alive, give age 75 years

8. AGE:

Years

Months

Days

If less than one day

79

1

1

hrs.

min.

9. Birthplace.....

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation.....

Waterman

11. Industry or business

self.

12. Name.....

John Goodman

13. Birthplace

Rock Hall, Md.

14. Maiden name.....

Rebecca Gleam

15. Birthplace

Rock Hall, Md.

16. Informant.....

John J. Williams

Address

Rock Hall, Md.

17. Burial

Date thereof. Oct 2 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wiley Chapel

Location

Rock Hall Kent Co. Maryland

18. Funeral director.....

J. Marvin V. Williams

Address

Chesapeake, Maryland

19. Dec'd 1. 1947

S. Edward Branson

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryeand

County Kent

City or town Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Baptist Driv

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

November 29 1947 at 10:5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 13 1947 to Nov 29 1947

and that I last saw h. in alive on 11-28 1947

immediate cause of death

Brown lung &amp; heart disease

Second cause of death

Due to Cancer of prostate and bladder

Due to Cancer of skin (rect.)

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

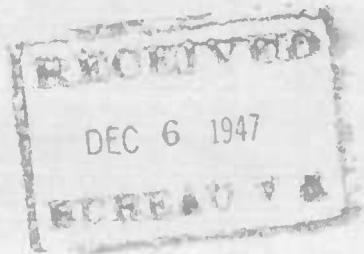
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Albert G. Burgeard M. D. or other

Address Rock Hall, Md. Date signed 11/29/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d  
10139

203

## CERTIFICATE OF DEATH

Reg. Diet. No. ....

## 1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

61 years

Hospital, institution, or street address where death occurred:

Fractiture Rd.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Wilhelmus Bernhard Heinefeld

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m.

White

widowed

6.(b) Name of husband or wife.....

Lena Heinefeld

7. Birth date of deceased (mo., day, yr.)

Jan 11 1874

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

73

9

25

hrs.

min.

9. Birthplace.....

Odeberg Germany

(Town, county, and state)

10. Usual occupation.....

Caretaker

11. Industry or business

owne

12. Name.....

Henry Heinefeld

13. Birthplace

Isleby

14. Maiden name.....

Anna Windolt

15. Birthplace

Germany

16. Informant.....

Albert Heinefeld

Address

Rock Hall, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof Jan 8-47

(month) (day) (year)

Cemetery or crematory

Gardley Chapel

Location

Rock Hall

18. Funeral director.....

Edgar L Lane

Address

Church Hall Rd

19. (Date rec'd by registrar)

19.

47

Elwood Burgess

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Fractiture Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

218-14-4345

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov 5

19.47, at 12<sup>30</sup>A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 4

19.47

to Nov 5

19.47

and that I last saw h.e. alive on Nov 4

19.47

19.47

## Immediate cause of death.....

Coronary occlusion

hypertension

arterio sclerosis

Due to.....

Valvular heart disease

Due to.....

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op.....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

.....

(State)

Means of injury .....

.....

Injured at work? .....

23. SIGNATURE.....

Albert A. Burgeard

M. D. or other

Address.....

Rock Hall, Md. Date signed 11-5-47

RECEIVED

NOV 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK.  
Supply every item of information carefully. The correct age  
is especially important. Physicians please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10144

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

93d

## 1. PLACE OF DEATH:

County.....

Kent

City or town.....

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all life

Hospital, institution, or street address where death occurred:

322 Cannon St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

William H. Sanding

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Blond Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

January 23, 1876

8. AGE:

Years

Months

Days

If less than one day

21 9 10 hrs. min.

9. Birthplace.....

Chesapeake, Kent Co., Maryland

(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business.....

Carpentry

MOTHER FATHER

12. Name.....

Perry H. Sanding

13. Birthplace.....

Kent Co., Maryland

14. Maiden name.....

Henrietta Wright

15. Birthplace.....

Kent Co., Maryland

16. Informant.....

Miss Henrietta Sanding (deceased)

Address.....

322 Cannon St., Chesapeake, Md.

17. Burial.....

Date thereof..... Nov. 4, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Chesapeake

Location.....

Chesapeake, Maryland

18. Funeral director.....

Francis V. Williams

Address.....

Chesapeake, Maryland

19. Nov. 4, 1947

(Date rec'd by registrar)

Clara S. Barnes, Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chesapeake (If outside city or town limits, write RURAL and give nearest town)

Street No..... 322 Cannon St. (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 2, 1947, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29, 1947, to Nov. 1, 1947,

and that I last saw h. im. alive on Nov. 1, 1947.

Immediate cause of death..... CEREBRO-VASCULAR

accident

Due to..... arteriosclerosis.

Due to.....

Other conditions..... cellulitis rt. thigh; Afternoon walk

heat disease; urmia;

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op. ....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

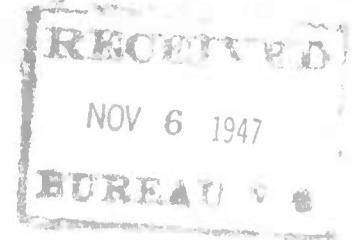
Injured at work?

23. SIGNATURE.....

A.R. Coppola, M.D.

M. D. or other

Address..... Chester Town, Md. Date signed..... 11-3-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10140

## CERTIFICATE OF DEATH

Reg. Dist. No. 2102

## 1. PLACE OF DEATH:

County.....

City or town..... Chesterlown Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11/27/47 to 11/29/47

Hospital, institution, or street address where death occurred:

Resident at 2nd Regd. Annex Hosp  
Chesterlown, Md

How long in hospital or institution?..... 11/27/47 to 11/29/47

## 3. (a) FULL NAME

Elizabeth G

Newsome

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife..... Clarence Newsome

7. Birth date of deceased (mo., day, yr.)

August 10, 1871

6. (c) If alive, give age ..... years

8. AGE:

Years 76 Months 3 Days 19 If less than one day hrs. min.

9. Birthplace.....

Washington, D. C.  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

Patrick Fallager

12. Name.....

Ireland

13. Birthplace.....

Bigid Goodwin

14. Maiden name.....

Ireland

15. Birthplace.....

Clarence Newsome

16. Informant.....

Burial

Cemetery or crematory.....

Chesterlown Md

17. (Burial, cremation, or removal. Which?)

Date thereof.....

B.R. Crematory

Address.....

Still Board and

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

1947

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Adent

City or town..... Betterton Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... November 29, 1947, at 9<sup>30</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 28, 1947, to November 29, 1947  
and that I last saw her alive on November 29, 1947

Immediate cause of death.....

Peritonitis

DURATION

18 hours

Due to Intestinal obstruction

48 hours

Due to Generalized carcinomatosis  
probably of ovarian origin

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations: Intestinal obstruction;

Generalized carcinomatosis. Date of op. 11-28-47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

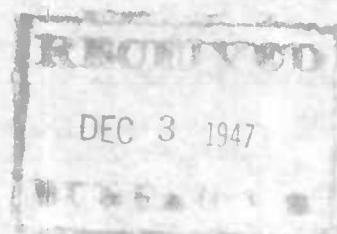
A.C. Dick, M.D.

M. D. or other

Address..... Chesterlown, Md Date signed..... 11-29-47

RECORDS TO THE STATE OF CALIFORNIA

RECORDED IN THE STATE OF CALIFORNIA



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

## CERTIFICATE OF DEATH

101201  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

Kent -

Kennedyville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6 months

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

## 3. (a) FULL NAME

Marcellus Nickerson

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male. White Widowed.

## 6.(b) Name of husband or wife.....

Ida Nickerson

## 7. Birth date of deceased (mo., day, yr.)

Aug 8 1866

6.(c) If alive, give age ..... years

## 8. AGE:

Years

Months

Days

If less than one day

81 1 27 hrs. min.

## 9. Birthplace.....

Deer Park Co. Md

(Town, county, and state)

## 10. Usual occupation.....

Farming

## 11. Industry or business

Farm

## 12. Name.....

John Nickerson

## 13. Birthplace

Deer Park Co. Md.

## 14. Maiden name.....

McGinnis

## 15. Birthplace

Deer Park Co. Md

## 16. Informant.....

William Pender

Kennedyville

## 17. Burial.....

Burial Date thereof Nov. 7. 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory.....

Crumpton

## Location.....

Crumpton Md

## 18. Funeral director.....

B. R. Collins

## Address.....

Still Sound Md.

## 19. Nov 6 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Kennedyville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Kennedyville Md

(If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 4 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 29 1947, to Nov 4 1947

and that I last saw him alive on Nov 4 1947

Immediate cause of death..... Cerebral

hemorrhage

Due to..... certain services

Due to..... Age

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

## 23. SIGNATURE.....

H. G. Thompson

M. D. or other

Address..... Chesapeake

Date signed..... Nov 6 1947

RECEIVED

DEC 4 1947

FEDERAL BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d  
10142  
8024

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Kent

City or town.....

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all life

Hospital, institution, or street address where death occurred:

211 Front St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Wallie Westcott Rogers

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Female

White

Married

P. Hyman Rogers

## 6.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

## 7. Birth date of deceased (mo. day, yr.)

March 29, 1881

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace.....

Kent Co. Maryland

(Town, county, and state)

## 10. Usual occupation.....

housewife

## 11. Industry or business.....

home

## MOTHER FATHER

## 12. Name.....

Wallie &amp; Westcott

## 13. Birthplace.....

Kent Co. Maryland

## 14. Maiden name.....

Polly Wickes

## 15. Birthplace.....

Kent Co. Maryland

## 16. Informant.....

P. Hyman Rogers

## Address.....

Chesapeake, Maryland

## 17. Burial.....

Burial

Date thereof..... Nov. 16, 1947

(month) (day) (year)

## Cemetery or crematory.....

Chesapeake

## Location.....

Chesapeake, Maryland

## 18. Funeral director.....

Marvin V. Williams

## Address.....

Chesapeake, Md.

## 19. Nov. 16, 1947

(Date rec'd by registrar)

Clara S. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Kent

City or town.....

County.....

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

111 Front St.

## 2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH.....

November 14

1947

at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

March 1, 1947, to Nov. 14, 1947,

and that I last saw her alive on Nov. 14, 1947.

Immediate cause of death.....

Fever, Jaundice

Duration

Due to.....

Key disorder

4 m

Due to.....

Astro scabies

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

No

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

## 23. SIGNATURE

Book Jones M.D.

M. D. or other

Address.....

Baltimore, Md.

Date signed

Nov. 17, 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10143

## CERTIFICATE OF DEATH

Reg. Dist. No. 2102

## 1. PLACE OF DEATH:

County.....

Tint

City or town.....

Worton P.O. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 years

Hospital, Institution, or street address where death occurred:

Churn Creek Farms

How long in hospital or institution?.....

## 3. (a) FULL NAME

Walter Scott Royer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

M. G. (late) Royer

6. (c) If alive, give age.....

75

years

7. Birth date of deceased (mo., day, yr.)

February 8, 1869

8. AGE:

Years

Months

Days

If less than one day

78

9

11

hrs.

min.

9. Birthplace.....

Carry, Ohio

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

12. Name.....

John Royer

Penn.

13. Birthplace.....

Emma Bonahue

14. Maiden name.....

Wayne Pa.

15. Birthplace.....

Mrs. Margaret Ruth Royer

Worton P.O. #1

Maryland

16. Informant.....

Address

Burial, cremation, or removal (which)

Date thereof.....

(month) (day) (year)

17. Removal

(Cemetery or crematory location)

Date thereof.....

(month) (day) (year)

18. Funeral director.....

Marvin V. Williams

Address

Chesapeake Maryland

19. Nov. 21, 1947

(Date rec'd by registrar)

Clara L. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Tint

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Churn Creek Farms

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

November 19

1947

at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-15

1947

to 11-19

1947

and that I last saw him alive on 11-18

1947

Immediate cause of death.....

Coronary artery disease

DURATION

2 years

Due to.....

Due to.....

Other conditions.....

Possible gastric ulcer

DURATION

2 mos.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

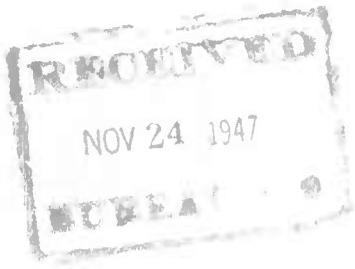
23. SIGNATURE.....

A. C. Dick, M.D.

M. D. or other

Address.....

Chester, Penn., U.S.A. Date signed 11-20-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and definitely.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10145

201

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

## 1. PLACE OF DEATH:

County

City or town

Kent -

Still Pond and

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Gwendolyn Theresia Simmons

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 24 1947

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

0

5

7

hrs.

min.

9. Birthplace

Dutchtown Kent Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Cliffton Simmons

13. Birthplace Clayton, Delaware

14. Maiden name Mary Redding

15. Birthplace Kent County

16. Informant

Mary Redding

Address

Dutchtown, Kent Co. Md.

17. Burial

Date thereof Nov 7 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt Zion

Location

Still Pond

18. Funeral director

B. P. Fellows

Address

Still Pond, Md.

19. Nov 6 1947

(Date rec'd by registrar)

J. McEach

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Kent

City or town

Still Pond and Rural

Street No.

Dutchtown

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 5 1947 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 5 1947 to

19.

and that I last saw her alive on Nov 5 1947

19.

Immediate cause of death

Bronchial Pneumonia

DURATION

1 day

Due to

Due to

Other conditions

malaria

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

L. P. Alwall

M. D. or other

Address

Still Pond

Date signed

11-6-47

RECORDED

DEC 4 1947

STERLING

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10146

## CERTIFICATE OF DEATH

Reg. Dist. No. 280

1. PLACE OF DEATH: Hart Co.  
 County.....  
 City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death? 10 daysHospital, Institution, or street address where death occurred: 30How long in hospital or institution? —3. (a) FULL NAME George F. Smith

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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6. (b) Name of husband or wife George Smith7. Birth date of deceased (mo., day, yr.) Sept 16, 18696. (c) If alive, give age 78 years

8. AGE: Years <u>78</u>	Months <u>1</u>	Days <u>28</u>	If less than one day hrs. <u>—</u> min. <u>—</u>
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9. Birthplace 903

(town, county, and state)

10. Usual occupation Patient Farmer

11. Industry or business

12. Name John13. Birthplace John14. Maiden name John15. Birthplace John16. Informant Wm. D. BrumleyAddress Burial Wellington Md17. Burial Date thereof Nov 15-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mc. Sistons Cor.Location near Graysboro Md18. Funeral director Edgar L. LaneAddress Church Street Md19. Date rec'd by registrar Nov. 14 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State MD County Hart Co.City or town Wellington (If outside city or town limits, write RURAL and give nearest town)Street No. — (If rural, give LOCATION)2.(a) If veteran, name war —

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1947 at 5 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Philadelphia 10 1947 to Nov 12 1947 and that I last saw him alive on Nov 10 1947Immediate cause of death Cerebral occlusionDue to Obesity PolyposisDue to Chronic AppendicitisOther conditions —

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE John J. McAllister M. D. or other —Address Wellington Md Date signed 11/13/47

RECEIVED

NOV 18 1947

BENKAU V